

BENEFIT HIGHLIGHTS *Prepared for*
City of Seguin- Active

BlueChoice Network

This is a general summary of your benefits. Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.

Overall Payment Provisions		In-Network Benefits	Out-of-Network Benefits
Deductibles			
Calendar Year Deductible Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses Three-month Deductible carryover applies	\$1,000 Individual / \$3,000 Family Yes	\$2,000 Individual / \$6,000 Family Yes	
Out-of-Pocket Maximum			
	\$4,000 Individual / \$12,000 Family	\$8,000 Individual / \$24,000 Family	
Deductibles applies to Out-of-Pocket Copayment applies to Out-of-Pocket	Yes – no option Yes – no option Network Deductible & Out-of-Pocket will only apply toward Network Deductible & Out-of-Pocket Maximum	Yes** Yes** Out-of-Network Deductible & Out-of-Network Out-of-Pocket will only apply toward Out-of-Network Deductible & Out-of-Network Out-of-Pocket Maximum	
** Copayment amounts and per admission deductibles are applied but will continue to be required after the benefit percentage increases to 100%.			
Copayment Amounts Required			
Physician office visit/consultation: Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider Refer to Medical/Surgical Expenses section for more information Urgent Care center visit Refer to Urgent Care section for more information Outpatient Hospital Emergency Room/Treatment Room visit Refer to Emergency Room/Treatment Room section for more information	\$20 Primary Care Copayment \$35 Specialty Care Copayment \$50 Copayment Amount \$200 Copayment Amount	 \$200 Copayment Amount	
Maximum Lifetime Benefits			
Per Participant	Unlimited		
Inpatient Hospital Expenses			
Inpatient Hospital Expenses			
All services must be preauthorized All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units Penalty for failure to preauthorize services	80% of Allowable Amount after Calendar Year Deductible None	60% of Allowable Amount after Calendar Year Deductible \$250	
Medical/Surgical Expenses			
Medical / Surgical Expenses			
Services performed during the office visit/consultation when rendered by a Primary Care Provider, including lab and x-ray (does not include Certain Diagnostic Procedures and surgical services) Services performed during the office visit/consultation when services rendered by a Specialty Care Provider, including lab & x-ray (does not include Certain Diagnostic Procedures and surgical services) -Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures) -Physician surgical services performed in any setting	100% of Allowable Amount after \$20 Primary Care Copayment** 100% of Allowable Amount after \$35 Specialty Care Copayment 100% of Allowable Amount 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible	

** Primary Care/Specialty Care copayments are defined in the Overall Payment Provisions section in this document.

Medical / Surgical Expenses, cont.		In-Network Benefits	Out-of-Network Benefits
-Physician inpatient hospital visits		80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
-Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan		80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
-Home Infusion Therapy (<i>Services must be preauthorized</i>)		80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
-All other outpatient services and supplies		80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
In Vitro Fertilization Services		Not Covered	
Extended Care Expenses			
Extended Care Expenses		100% of Allowable Amount	60% of Allowable Amount after Calendar Year Deductible
<i>All services must be preauthorized</i>			
Skilled Nursing Facility		Limited to 25 day maximum each Calendar Year*	
Home Health Care		Limited to 60 visit maximum each Calendar Year*	
Hospice Care		Unlimited	
Special Provisions Expenses			
Serious mental illness			
Mental Health Care			
Treatment of Chemical Dependency			
Inpatient Services (All services must be preauthorized)			
-Hospital services (facility)		80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
(Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency Treatment Center)			
-Physician services		80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Penalty for failure to preauthorize services		None	\$250
Outpatient Services (Certain services must be preauthorized; refer to benefit booklet for details)			
-Services performed during office visit/consultation when rendered by a Primary Care Provider (does not include psychological testing)		100% of Allowable Amount after \$20 Primary Care Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
-All outpatient services and psychological testing		80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Emergency Room/Treatment Room			
Accidental Injury & Emergency Care			
-Facility charges		80% of Allowable Amount after \$200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)	
-Physician charges		80% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Care			
-Facility charges		80% of Allowable Amount after \$200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)	60% of Allowable Amount after \$200 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)
-Physician charges		80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Urgent Care Services			
Urgent Care center visit, including lab & x-ray services (<i>does not include Certain Diagnostic Procedures and surgical services</i>)		100% of Allowable Amount after \$50 Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies		80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-Network Benefits
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, and any other preventive health services as determined by USPSTF	100% of Allowable Amount	60% of Allowable Amount after Calendar Year Deductible
Immunizations for Dependent children through the date of the child's 6 th birthday	100% of Allowable Amount	100% of Allowable Amount
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function	Covered same as any other sickness	Covered same as any other sickness
Hearing Aids	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Hearing Aid Maximum	Hearing aids are subject to 1 per ear per 36 month period	
Organ and Tissue Transplant Services		
	Covered same as any other sickness Refer to benefit booklet for details	Covered same as any other sickness Refer to benefit booklet for details
Physical Medicine Services		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	Limited to 35 visits each Calendar Year*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Pharmacy Benefits

Participating Pharmacy*

**Non-Participating Pharmacy
(member files claim)**

Drug List**	Preferred Drug List 1							
Prescription Drug Out-of-Pocket Maximum	☒ Separate Prescription Drug Out-of-Pocket Maximum applies: \$1000 combined Retail & Mail Service Pharmacy Out-of-Pocket Maximum per Calendar Year.							
Vaccinations obtained through Pharmacies****	Yes, flu vaccinations covered as follows: <table><tr><td>Select pharmacies participating in Flu Network – 100%</td><td>80% of Allowable Amount minus Copayment Amount</td></tr><tr><td>All other in-network pharmacies – appropriate tier copay applies</td><td></td></tr></table>		Select pharmacies participating in Flu Network – 100%	80% of Allowable Amount minus Copayment Amount	All other in-network pharmacies – appropriate tier copay applies			
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All other in-network pharmacies – appropriate tier copay applies								
Retail Pharmacy (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to Out-of-Pocket Maximum.) Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	<table><tr><td>\$10 Copayment Amount</td><td>80% of Allowable Amount minus Copayment Amount</td></tr><tr><td>\$30 Copayment Amount</td><td>80% of Allowable Amount minus Copayment Amount</td></tr><tr><td>\$60 Copayment Amount</td><td>80% of Allowable Amount minus Copayment Amount</td></tr></table>		\$10 Copayment Amount	80% of Allowable Amount minus Copayment Amount	\$30 Copayment Amount	80% of Allowable Amount minus Copayment Amount	\$60 Copayment Amount	80% of Allowable Amount minus Copayment Amount
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\$30 Copayment Amount	80% of Allowable Amount minus Copayment Amount							
\$60 Copayment Amount	80% of Allowable Amount minus Copayment Amount							
Specialty Drugs†	Available at any pharmacy at applicable generic/brand name and participating/non-participating pharmacy benefit level.							
Mail Order Program (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to Out-of-Pocket Maximum.) Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	<table><tr><td>Yes</td></tr><tr><td>\$10 Copayment Amount</td></tr><tr><td>\$30 Copayment Amount</td></tr><tr><td>\$60 Copayment Amount</td></tr></table>		Yes	\$10 Copayment Amount	\$30 Copayment Amount	\$60 Copayment Amount		
Yes								
\$10 Copayment Amount								
\$30 Copayment Amount								
\$60 Copayment Amount								
Rx Enhanced-Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when “Brand Medically Necessary” is not indicated and a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Preferred/Non-Preferred Brand Name Drug, plus the Preferred Brand Name Copayment Amount. If “Brand Medically Necessary” is indicated on the prescription, the member will pay the Preferred or Non-Preferred Brand Name Copayment Amount.								
All medications with over-the-counter (OTC) equivalents are excluded from coverage except for Omeprazole 20 mg.								
* To locate a participating pharmacy in your area go to myprime.com or contact customer service at the phone number on the back of your identification card.								
**The preferred drug list is available at: bcbstx.com/member/rx_drugs.html								
*** Three-month Deductible carryover does not apply to prescription drug deductible.								
**** Select pharmacies participating in the Flu Network are contracted to provide vaccination services. Flu vaccinations at all other in-network and out-of-network pharmacies are payable at the non-participating Flu Network pharmacy benefit level. Each pharmacy may have age, scheduling, or other requirements that will apply. You are encouraged to contact the store in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.								
†For more information on the specialty drug program, call Prime Specialty Pharmacy at (877)627-6337.								
Diabetes Supplies are available under the Prescription Drug benefits of your plan. Diabetic Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucagon emergency kits, and other injection aids. All provisions of this portion of the plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.								

EMPLOYEE INFORMATION

The following benefits apply to dependent coverage:

- Dependent children are covered for maternity benefits.
- Dependent children are covered to age 26.
- Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.

Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are also based on the BCBSTX-determined Allowable Amount. Covered individuals will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas State law, the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the contract date):

- Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
- Eligible expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

Members residing in other states may use that state's network through the BlueCard program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our web site at bcbstx.com to use our Provider Finder® tool.

This benefit plan design includes provisions mandated by the Affordable Care Act of 2010, and is subject to change upon direction by federal and state agencies.